Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05402-0070
medicalboard@vdh.state.vt.us
802-657-4220 or 800-745-7371

APPLICATION FOR REINSTATEMENT OF LAPSED LICENSE- PHYSICIAN - MEDICAL DOCTOR - INSTRUCTIONS AND CHECKLIST

Thank you for your interest in reinstating your lapsed medical license in Vermont.

Enclosed please find the application for reinstatement of lapsed license. If you would like to check the status of your application, please contact the board office. Normally, it takes a minimum of six weeks to complete the process.

Any applicant with a disability who needs an accommodation should contact the Board office.

The following is a list of documents required (Unless noted, a copy of the original and **English translation, if applicable** is required to be submitted).

1) Enclose fee of $500. Check made payable to the Vermont Department of Health.
   - ***Note: If requesting reinstatement of licensure less than one year from date of lapse, complete a physician renewal application and submit the required late fee ($25 plus $5 for every additional month or fraction of a month) and the renewal fee.***

2) Complete "APPLICATION FOR REINSTATEMENT OF LAPSED LICENSE."

3) Obtain **direct verification.** The "CERTIFICATE OF MEDICAL LICENSURE" must be completed by the Medical Board of each state where you hold or have held a license. **Copies of licenses are not accepted**.

4) Three (3) Completed Reference Forms mailed **directly** to the Board **by the Chief of Staff of EACH hospital where you have held privileges during the period your Vermont license lapsed (if necessary, photocopy this form)**. Program Director should be substituted for Chief of Staff for applicants who are applying for reinstatement while still in residency training or have completed a residency within the last year.

5) **Information on your professional activities in any other jurisdiction** during the period your license has lapsed (curriculum vitae (CV/Resume) may be attached to fulfill this requirement)

6) Send American Medical Association Profile Form. **Must be sent by the applicant directly to the AMA.**

7) Send National Practitioner Data Bank self query. **Send the original, unaltered response to the Board.**

8) Personal Interview Required: As soon as your application is complete and the review process is finished, you will be provided with the name, address, and telephone number of the Medical Board member you are to contact for a personal interview.

9) Complete enclosed Form A if you answered "Yes" in Sections III-VI.

10) Your Signature Required:

    Photograph in Section VI
    End of Section VII
    Form B: Release

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, P.O. Box 70
Burlington, VT 05402

APPLICATION FOR REINSTATEMENT OF LAPSED LICENSE PHYSICIAN–MEDICAL DOCTOR

I hereby apply for REINSTATEMENT OF MY LAPSED LICENSURE AS A PHYSICIAN in the state of Vermont.

Part I - Identity Questions

1. Print your full name as you wish it to appear on the license:

_____

Last Name First Name Middle Name Suffix

2. Have you ever legally changed your name? **___Yes ___ No**
If yes, enclose a certified copy of the legal document stating the change.

Other name(s), if any under which you were licensed elsewhere:

_____

Last Name First Name Middle Name Suffix

3. Your Date of Birth:____/____/____
Month/Day/Year

4: Your mailing address: (Check one: □ home address □ work address)

Care of: _____

Street: _____

Town/City: _____

State: _____

Zip: _____

5. Your contact information:

Home telephone number with area code: (_____)_____

Work telephone number with area code: (_____)_____

E-mail Address: _____

____ Please check here if the Department of Health may use this e-mail address to send you public health information

6. Were you in active practice in Vermont in the past 12 Months? ___ **Yes** ___ **No**

7. Years of Practice [See 26 VSA § 1368(a)(10)]

Month and year you started practicing as a physician (excluding residency/fellowship training)?

_____

8. Have you ever held a Vermont Limited Temporary License: ___**Yes** ___ **No**
If yes, License Number _____

9. Do you hold, or have you ever held, a medical license in any other state? ___ **Yes** ___**No**

If yes, complete the section below:

State	**License Number**	**Type of License**	**Date Issued**	**Status(Active or Inactive)**

If necessary, please use an additional sheet and check this box: .....□

Part II – Education, Training, Practice and Examinations

10. Premedical Education

Please provide the names of premedical schools you attended and the dates of attendance.

Name and location of institution	**Degree**	**From**	**To**

If necessary, please use an additional sheet and check this box: .....□

11. Medical Professional Schools

Please provide the name of the medical professional school you attended and the date of graduation. (We will have similar information on file with your original application; we are asking you here to provide an update for the statutory web profile.)

_____
(School/Institution) (City) (State) (Year of Graduation)

If necessary, please use an additional sheet and check this box: .....□

12. Graduate Medical Education

Please provide the names of graduate medical schools you attended and the dates of attendance.

_____

(School/Institution) (Specialty) (City) (State) (Year of Graduation)

_____

(School/Institution) (Specialty) (City) (State) (Year of Graduation)

_____

(School/Institution) (Specialty) (City) (State) (Year of Graduation)

If necessary, please use an additional sheet and check this box: .....□

13. Specialty Board Certification

Enter up to three specialty codes from the enclosed ***Specialty Codes List***. List your primary specialty first. If you cannot locate a specialty, please write the specialty name in the space provided.

Specialty Code				Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
					□ yes □ no			
					□ yes □ no			
					□ yes □ no			

14. Examinations

USMLE____ FLEX____ National Board____ LMCC____

State Exam____ Which State? _____ If yes, make sure that the scores are included on the Certificate of Medical Licensure to be sent to that Board.

15. International Medical Graduates

A. ECFMG Standard Certificate Number: _____Date issued: _____

B. Are you a graduate of a fifth pathway program: ____ Yes _____ No

16. Practice

Do you have hospital privileges? ____ Yes _____ No

List all hospitals where you have, or previously have had, staff privileges. Include name, address, and dates.

Name	Address	From/To	Specialty/Subspecialty

Part III - Licensure and Practice Questions

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

17. Have you ever applied for and been denied a license to practice medicine or any other healing art?
___Yes ___No

18. Have you ever withdrawn an application for a license to practice medicine or any other healing art?
___Yes ___No

19. Have you ever voluntarily surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action?
___Yes ___No

20. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
___Yes ___No

21. Have you ever been denied the privilege of taking an examination before any state medical examining board?
___Yes ___No

22. Have you ever discontinued your education, training, or practice for a period of more than three months, for reasons other than a family situation?
___Yes ___No

23. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
___Yes ___No

24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?
___Yes ___No

25. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
___Yes ___No

26. Are you presently a defendant in a criminal proceeding?
___Yes ___No

Part IV - Confidential Section

Part III is exempt from public disclosure

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

27. To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application?

___Yes ___No

28. To your knowledge, are you presently the subject of criminal investigation?

___Yes ___No

MEDICAL QUESTIONS

Please answer "**Yes**" or **"No**" to the questions below. Definitions are provided to assist you in answering. Please explain any "**Yes**" answers on Form A.

DEFINITIONS

In answering the questions above, please use these definitions:

"**Ability to practice medicine**" - This term includes:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"**Medical condition**" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"**Currently**" - This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"**Chemical substances**" - This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"**Controlled substances**" - This term means those drugs listed on Schedules I through V of Section 202 of the
Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

29. Do you have a medical condition that in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

___Yes ___No

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

30. Are you currently engaged in the use of alcohol or other chemical substances that in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

___Yes ___No

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

31. Are you currently engaged in the illegal use of controlled substances?

___Yes ___No

In explaining a "Yes" answer on Form A, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

IMPORTANT

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line).

Part V - Statutory Profile Questions

Vermont law, 26 VSA § 1368, creates a data repository within the Department of Health. Under this law, the Department must collect certain information to create individual profiles on all health care professionals licensed, certified, or registered by the Department pursuant to Title 26 of the VSA. Please try to answer the following questions as best as you can. You will receive a copy of your profile prior to its initial release to the public and each time the profile is modified or amended. You will be given a reasonable time to correct factual inaccuracies that appear in such profile. As noted below, certain questions do not need to be answered.

It is very important for us to receive photostatic copies of court papers, licensing authority decisions, and other documents relevant to the questions below in order to have a true and accurate description of the actions taken.

32. **Criminal Convictions** [See 26 VSA § 1368(a)(1)]

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted. For purposes of this question, "convicted" means that you pleaded guilty or that you were found or adjudged guilty by a court of competent jurisdiction. Please provide copies of papers fully documenting the convictions.

(Conviction Date)	(Court)	(City/State)	(Crime)
(Conviction Date)	(Court)	(City/State)	(Crime)

If necessary, please use an additional sheet and check this box: .....□

33. **Nolo Contendere/Matters Continued** [See 26 VSA § 1368(a)(2)]

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction. Please provide copies of papers fully documenting these matters.

(Conviction Date)	(Court)	(City/State)	(Charge)
(Conviction Date)	(Court)	(City/State)	(Charge)

If necessary, please use an additional sheet and check this box: .....□

34. **Vermont Board of Medical Practice Matters** [See 26 VSA § 1368(a)(3)]

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed. (We will have the documentation on file; we are asking you to provide the description.)

(Date)	(Final Disposition – Summary)

If necessary, please use an additional sheet and check this box: .....□

35. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]

Please provide a description of all formal charges served by licensing authorities of other states, the findings, conclusions, and orders of such licensing authorities, and final disposition of such matters by the courts, if appealed, in those states. Please provide copies of papers fully documenting these matters.

_____

(Date of Final Disposition) (Licensing Authority) (Court) (City/State) (Nature of Charge)

If necessary, please use an additional sheet and check this box: .....□

36. **Restriction of Hospital Privileges** [See 26 VSA § 1368(a)(5)]

A. Revocation/Involuntary Restrictions

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. Please provide copies of papers fully documenting these matters.

_____

(Date) (Hospital) (State) (Nature of Restriction) (Reason for Restriction)

If necessary, please use an additional sheet and check this box: .....□

B. Other Restrictions

Please provide a description of all resignations from, or nonrenewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. Please provide copies of papers fully documenting these matters.

_____

(Date) (Hospital) (State)

_____

(Nature of Action) (Action) (Reason for Action)

□ In Lieu □ In Settlement

If necessary, please use an additional sheet and check this box: .....□

37. **Medical Malpractice Court Judgments/Settlements** [See 26 VSA § 1368(a)(6A)]

A. Judgments

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases; complete Form A and provide copies of papers fully documenting these matters.

□ Judgment □ Arbitration

(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Against You)

If necessary, please use an additional sheet and check this box: .....□

B. Settlements

Please provide a description of all pending settlements and settlements of medical malpractice claims against you. Please complete Form A and provide copies of papers fully documenting these matters.

(Date)	(Court)	(State)	(Amount Assessed Against You)

If necessary, please use an additional sheet and check this box: .....□

38. **Appointments/Teaching** [See 26 VSA § 1368(a)(12)] Note: Answering #38 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

Please provide information about your appointments to medical school or professional school faculties.

(School)	(City)	(State)	(Nature of Appointment)	From (year)	To (year)
(School)	(City)	(State)	(Nature of Appointment)	From (year)	To (year)

If necessary, please use an additional sheet and check this box: .....□

B. Teaching

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years.

(School/Institution)	(City)	(State)	(Nature of Teaching)	From (year)	To (year)

_____

(School/Institution) (City) (State) (Nature of Teaching) From (year) To (year)

If necessary, please use an additional sheet and check this box: .....□

39. **Publications** [See 26 VSA § 1368(a)(13)] Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

_____

(Title) (Publication) (Year)

_____

(Title) (Publication) (Year)

If necessary, please use an additional sheet and check this box: .....□

40. **Activities** [See 26 VSA § 1368(a)(14)] Note: Answering #40 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your professional or community service activities and awards.

_____

_____

(Activities or Awards)

If necessary, please use an additional sheet and check this box: .....□

- End of Statutory Profile Questions -

41. **Interview**

A. In which part of Vermont would you prefer to be interviewed? (Northern – Burlington area, Southern – Bennington, Springfield, Central – Montpelier area, or using video technology)_____

B. When are you scheduled to begin work in Vermont? _____

C. What has been your physical residence (city, state) in the past ten years?

_____

_____

Part VI - Photograph

PLEASE PROVIDE A PHOTOGRAPH:
Attach a recent photograph (head and shoulders). Please sign the front of the photograph. Do not use staples

PHOTOGRAPH

Part VII - Signature

Reminder - You must also complete and sign the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions, Form B, and authorizations for release of information as appropriate, Form C.

I hereby aver that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date:_____ _____
Applicant's Signature

Return completed application to:

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, P0 Box 70
Burlington VT 05402-0070

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

1. You must check one of the two statements below regarding child support regardless whether or not you have children:

- ❑ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

or

- ❑ I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due and payable and all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

2. You must check one of the two statements below regarding taxes:

- ❑ I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000.00 fine or both).

or

- ❑ I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contributions:

- ❑ I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a $10, 000.00 fine or both.)

or

- ❑ I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.

or

- ❑ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* _____/_____/_____ Date of Birth _____/_____/

* The disclosure of your social security number is mandatory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

STATEMENT OF APPLICANT

I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant_____ Date_____

FORM B

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

FORM B: 1) AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION AND 2) AUTHORIZATION TO COMMUNICATE WITH FUTURE EMPLOYERS REGARDING THE STATUS OF YOUR APPLICATION

TO WHOM IT MAY CONCERN:

1) I, _____, HEREBY AUTHORIZE YOU to furnish to the
(Name of Applicant)

Vermont Board of Medical Practice or its designated representative, all materials and information within your possession or control relating to me, of whatever kind and wherever located and including, but not limited to, my education, my professional experience and qualifications, my licensing history, my practice as a physician, civil and criminal court records, and any other material or information, including investigative files, which, in the sole discretion of the Vermont Board of Medical Practice, may be useful to said Board in its review of my licensing status.

Only in regard to this specific authorization for disclosure to the Vermont Board of Medical Practice and for no other purpose, I expressly WAIVE confidentiality and any privileges or immunities accorded this information by State or Federal Law, and I hold you harmless from disclosure of same to the Vermont Board of Medical Practice.

YOU ARE ALSO AUTHORIZED to report information, either orally or in writing, directly to the Vermont Board of Medical Practice or its designated representative on a continuing basis until this authorization is revoked, by me, in writing.

A CONFORMED PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL SERVE IN ITS STEAD.

2) I further authorize the Vermont Board of Medical Practice to communicate with future employers and/or locum tenens companies regarding the status of my application for licensure.

Signature: _____

Date: _____

Print or Type Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: (_____) _____

Subscribed and sworn to before me, this _____ day of _____.

_____
Notary Public

Affix Seal My License Expires: _____

RETURN ORIGINAL TO THE BOARD WITH YOUR APPLICATION
SEND COPIES WITH THE REFERENCE FORMS

SPECIALTY CODES LIST

(primary care specialties in boldface)

0101	Allergy and Immunology
0102	Clinical & Laboratory Immunology
0201	Anesthesiology
0202	Critical Care Medicine
0203	Pain Management
0301	Colon & Rectal Surgery
0401	Dermatology
0402	Dermatopathology
0403	Clinical & Laboratory Dermatology
0404	Dermatological Immunology
0501	Emergency Medicine
0502	Medical Toxicology
0503	Pediatric Emergency Medicine
0504	Sports Medicine
0601	**Family Practice**
0602	**Geriatric Medicine**
0603	Sports Medicine
0701	**Internal Medicine**
0702	**Adolescent Medicine**
0703	Cardiac Electrophysiology
0704	Cardiovascular Disease
0705	Critical Care Medicine
0706	Clinical & Lab Immunology
0707	Endocrinology Diabetes & Metabolism
0708	Gastroenterology
0709	**Geriatric Medicine**
0710	Hematology
0711	Infectious Disease
0712	Medical Oncology
0713	Nephrology
0714	Pulmonary Disease
0715	Rheumatology
0716	Sports Medicine
0801	Medical Genetics
0802	Clinical Biochemical Genetics
0803	Clinical Biochemical/Molecular Genetics
0804	Clinical Cytogenetics
0805	Clinical Genetics (Md)
0806	Clinical Molecular Genetics
0901	Neurological Surgery
0902	Critical Care Medicine
1001	Nuclear Medicine
1101	**Obstetrics & Gynecology**
1102	Critical Care Medicine
1103	Gynecologic Oncology
1104	Maternal & Fetal Medicine
1105	Reproductive Endocrinology
1201	Ophthalmology
1301	Orthopaedic Surgery
1302	Hand Surgery
1401	Otolaryngology
1402	Otology/Neurotology
1403	Pediatric Otolaryngology
1501	Anatomic & Clinical Pathology
1502	Anatomic Pathology
1503	Clinical Pathology
1504	Blood Banking/Transfusion Medicine
1505	Chemical Pathology
1506	Cytopathology
1507	Dermatopathology
1508	Forensic Pathology
1509	Hematology
1510	Immunopathology
1511	Medical Microbiology
1512	Neuropathology
1513	Pediatric Pathology
1601	**Pediatrics**
1602	**Adolescent Medicine**
1603	Clinical & Laboratory Immunology
1604	Medical Toxicology
1605	Neonatal-Perinatal Medicine
1606	Pediatric Cardiology
1607	Pediatric Critical Care Medicine
1608	Pediatric Emergency Medicine
1609	Pediatric Endocrinology
1610	Pediatric Gastroenterology
1611	Pediatric Hematology-Oncology
1612	Pediatric Infectious Disease
1613	Pediatric Nephrology
1614	Pediatric Pulmonology
1615	Pediatric Rheumatology
1616	Pediatric Sports Medicine
1617	Children with Special Health Needs
1701	Physical Medicine & Rehabilitation
1801	Plastic Surgery
1802	Hand Surgery
1901	Preventive Medicine
1902	Aerospace Medicine
1903	Occupational Medicine
1904	Public Health & General Preventive
1905	Medical Toxicology
1906	Underseas Medicine
	Psychiatry & Neurology (Board Name - Not A Specialty)
2001	Psychiatry
2002	Neurology
2003	Neurology With Special Qualifications In Child Neurology
2004	Addiction Psychiatry
2005	Child & Adolescent Psychiatry
2006	Forensic Psychiatry
2007	Geriatric Psychiatry
2008	Clinical Neurophysiology
2101	Radiology
2102	Diagnostic Radiology
2103	Radiation Oncology
2104	Radiological Physics
2105	Nuclear Radiology
2106	Pediatric Radiology
2107	Vascular & Interventional Radiology
2201	Surgery
2202	Surgery Of The Hand
2203	Pediatric Surgery
2204	Surgical Critical Care
2205	General Vascular Surgery
2301	Thoracic Surgery
2401	Urology
4001	Abdominal Surgery
4002	Acupuncture
4003	Addiction Medicine
4004	Adult Reconstructive Orthopedics
4005	Allergy
4006	Cardiovascular Surgery
4007	Clinical Pharmacology
4008	Diabetes
4009	Facial Plastic Surgery
4010	**General Practice**
4011	**Gynecology**
4012	Head & Neck Surgery
4013	Hepatology
4014	Homeopathic Medicine
4015	Immunology
4016	Legal Medicine
4017	Musculoskeletal Oncology
4018	Neuroradiology
4019	Nutrition
4020	**Obstetrics**
4021	Oral & Maxillofacial Surgery
4022	Orthopedic Surgery Of The Spine
4023	Orthopedic Trauma
4024	Pain Medicine
4025	Pediatric Allergy
4026	Pediatric Ophthalmology
4027	Pediatric Orthopedics
4028	Pediatric Surgery (Neurology)
4029	Pediatric Urology
4030	Psychoanalysis
4031	Radioisotopic Pathology
4032	Sports Medicine (Orthopedic Surgery)
4033	Traumatic Surgery
4034	Sleep Medicine
9001	Rotating Internship (Residency)
9999	Other - Please Specify

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 17 and 18) Withdrawal or denial of License - Attach documents

State_____ Year_____
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated_____

_____

(Question 19) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State_____ Year_____

Circumstances_____

_____

(Question 20) Disciplinary charges or action - Attach documents

Name of organization involved_____ Date_____

Duration_____

Action taken (circle all that apply)

01 Revocation of right or privilege
02 Suspension of right or privilege
03 Censure
04 Written reprimand or admonition
05 Restriction of right or privilege
06 Non-renewal of right or privilege
07 Fine
08 Required performance of public service
09 Education/Training/Counseling/Monitoring
10 Denial of rights or privilege
11 Resignation
12 Leave of absence
13 Withdrawal of an application
14 Termination or non-renewal of contract
15 Medical Records Suspension
16 Probation
17 Assurance of Discontinuance
18 Consent Agreement
19 Letter of Agreement
20 Expulsion from Membership
21 Reprimand
22 Other (specify)_____

Circumstances_____

_____

_____

(Question 21) Denial of examination privileges - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

_____

(Questions 22 and 23) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances_____

_____

(Question 24) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances_____

_____

(Question 25) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

_____

(Questions 26 and 28) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status_____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

(Question 27) Investigation by any other licensing board - Attach documents

Name of Licensing Board_____ Date _____

Location of Licensing Board_____

Circumstances_____

(Questions 29-31) Medical condition, treatment, use of chemical or illegal substances

Treating organization _____

Address _____Telephone _____

Type of diagnosis, condition or treatment - field of practice - use of chemical substances

_____

_____

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____Telephone _____

Contact person at Program _____

(Question 37) Medical Malpractice Claim

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.

Insurer_____

Claimant name _____

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

Please indicate:
1. Patient's condition at point of your involvement;
2. Patient's condition at end of treatment;
3. The nature and extent of your involvement with the patient;
4. Your degree of responsibility for the course of treatment in leading to the claim; and
5. Narrative of event.

_____

_____

_____

_____

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

_____

Your role (circle one):

01 Anesthesiologist	11 PGY 4
02 Primary Care Physician	12 PGY 5
03 Referring Physician	13 PGY 6
04 Attending Physician	14 PGY 7
05 Consultant Specialist	15 Workmen's Compensation Evaluator
06 Surgeon	16 Court Psychiatrist
07 Fellow	17 On-Call Physician
08 PGY 1	18 Group Practitioner/Partner
09 PGY 2	19 Other: Specify _____
10 PGY 3	20 Unknown

Your Legal Representative in this matter (include name, address and telephone number)

Name _____

Firm _____

Address _____

City, State, Zip _____

Phone _____

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:

Court_____

Court's location_____

Docket number_____

Date the action was filed_____

Decision determined by (check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date appeal filed (month, day, year) _____/_____/_____
Date appeal decided: (month, day, year) _____/_____/_____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of settlement: (month, day, year) _____/_____/_____

_____ Case dismissed against you _____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

_____

_____

_____

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

CERTIFICATE OF MEDICAL LICENSURE

This section must be completed by the regulatory authority in the states in which **you now hold** or have **ever held** a license to practice medicine.

I, _____ Secretary of the

_____ State Board of Medical Examiners, certify that

_____

was granted Certificate Number _____ to practice medicine in the

State of_____ on the

_____ day of _____, 19_____,

based on _____ and that said certificate has never been revoked,

suspended or conditioned in any way, or the licensee has never been disciplined by the Board in any way.

NOTE: If licensed by written examination the secretary should further certify:

I further certify that the aforesaid _____ in his/her written

examination before this Board, obtained a general average of _____ percent in the

following branches:

(The subjects of the examination and rating of each must be stated in full.)

_____

_____

_____

(AFFIX SEAL) _____ _____
(Secretary/Director) (Date)

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

LIST OF THREE REFERENCES

Detach the attached Reference Forms and send to the individuals designated below* ALONG WITH A COPY OF THE SIGNED FORM B RELEASE. Return this sheet to the Board with your application. Individuals completing the reference forms must return the forms directly to the Board.

***NOTE: Program Director should be substituted** for Chief of Service for applicants who are applying for a license while still in residency training or have completed a residency within the last year. **(SEE ATTACHED SEPARATE FORM FOR PROGRAM DIRECTOR.)**

Names, addresses and telephone numbers of three references:

1) Reference #1 - Chief of Service (See Program Director Note * above): _____

Address: _____

_____

City, State, Zip Code: _____

Telephone: (_____) _____

How long and in what capacity has this individual known you? _____

2) Reference #2 - Active physician staff member at the hospital where you have a current or recent appointment:

Name: _____

Address: _____

_____

City, State, Zip Code: _____

Telephone: (_____) _____

How long and in what capacity has this individual known you? _____

3) Reference #3 - Active physician staff member at the hospital where you have a current or recent appointment:

Name: _____

Address: _____

_____

City, State, Zip Code: _____

Telephone: (_____) _____

How long and in what capacity has this individual known you? _____

Note: If you are unable to provide references from these individuals because you have never held hospital privileges, attach such an explanation to this form when you submit your application. Three other references from physicians you have worked with most recently will then be required.

REFERENCE FORM #1: SEND TWO PAGES

CHECK TO SEE IF PROGRAM DIRECTOR FORM IS APPLICABLE

Chief of Service Form
Return Directly to Board

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

REFERENCE FORM TO BE COMPLETED BY CHIEF OF SERVICE, PAGE ONE OF TWO

Name of Applicant: _____

The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. **Thank you for your cooperation.**

Please complete all parts of this form. If more room is needed, please attach additional information.

Dr. _____ was at _____

from _____ to _____. During that time, he/she was

(List status in the Institution): _____.

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

Basic medical knowledge:	____ Poor	____ Fair	____ Average	____ Above Average
Professional judgment:	____ Poor	____ Fair	____ Average	____ Above Average
Sense of responsibility	____ Poor	____ Fair	____ Average	____ Above Average
Moral character/ ethical conduct:	____ Poor	____ Fair	____ Average	____ Above Average
Competence and skill:	____ Poor	____ Fair	____ Average	____ Above Average
Cooperativeness, ability to work with others:	____ Poor	____ Fair	____ Average	____ Above Average
History & physical exam taking:	____ Poor	____ Fair	____ Average	____ Above Average
Record keeping	____ Poor	____ Fair	____ Average	____ Above Average
Case presentations:	____ Poor	____ Fair	____ Average	____ Above Average
Patient management:	____ Poor	____ Fair	____ Average	____ Above Average
Physician-Patient relationship:	____ Poor	____ Fair	____ Average	____ Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	____ Poor	____ Fair	____ Average	____ Above Average
Participation in Medical Staff Affairs	____ Poor	____ Fair	____ Average	____ Above Average

Chief of Service Form
Continued

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

REFERENCE FORM TO BE COMPLETED BY CHIEF OF SERVICE, PAGE TWO OF TWO

Name of Applicant: _____

How long have you known the applicant and in what capacity? _____

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? _____ Yes _____ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine? _____ Yes _____ No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? _____ Yes _____ No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.) _____ Yes _____ No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? _____ Yes _____ No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? _____ Yes _____ No

Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? _____ Yes _____ No

Do you know of a failure of the applicant to complete a residency training program(s)? _____ Yes _____ No

Does the applicant call upon consults when needed? _____ Yes _____ No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluating this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

_____ Close personal observation
_____ General impression
_____ A composite of faculty/staff evaluations
_____ Other - Specify: _____

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend _____ for licensure in Vermont.
Name of Physician

Signed: _____ Date: _____

Print or Type Name and Title: _____

PROGRAM DIRECTOR FORM
SEND THREE PAGES

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

RESIDENCY EVALUATION FORM TO BE SUBMITTED TO THE BOARD
IF YOU ARE STILL IN RESIDENCY TRAINING OR
HAVE COMPLETED A RESIDENCY WITHIN THE LAST YEAR

Detach the attached Evaluation Form and send it to your Program Director ALONG WITH A COPY OF THE SIGNED FORM B RELEASE. Return this sheet to the Board with your application. The Program Director completing the evaluation form must return the form directly to the Board.

Name, address and telephone number of your Program Director:

1) Name of Program Director: _____

Address: _____

_____

_____

City, State, Zip Code: _____

Telephone: (_____) _____

Program Director Form
Return Directly to Board

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

EVALUATION FORM TO BE COMPLETED BY PROGRAM DIRECTOR, PAGE ONE OF THREE

Name of Applicant: _____

The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following evaluation form. **Thank you for your cooperation.**

Please complete all parts of this form. If more room is needed, please attach additional information.

Dr. _____ was at _____

from _____ to _____. During that time, he/she was

(List status in the Institution): _____.

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

Basic medical knowledge:	____ Poor	____ Fair	____ Average	____ Above Average
Professional judgment:	____ Poor	____ Fair	____ Average	____ Above Average
Sense of responsibility	____ Poor	____ Fair	____ Average	____ Above Average
Moral character/ ethical conduct:	____ Poor	____ Fair	____ Average	____ Above Average
Competence and skill:	____ Poor	____ Fair	____ Average	____ Above Average
Cooperativeness, ability to work with others:	____ Poor	____ Fair	____ Average	____ Above Average
History & physical exam taking:	____ Poor	____ Fair	____ Average	____ Above Average
Record keeping	____ Poor	____ Fair	____ Average	____ Above Average
Case presentations:	____ Poor	____ Fair	____ Average	____ Above Average
Patient management:	____ Poor	____ Fair	____ Average	____ Above Average
Physician-Patient relationship:	____ Poor	____ Fair	____ Average	____ Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	____ Poor	____ Fair	____ Average	____ Above Average
Participation in Medical Staff Affairs	____ Poor	____ Fair	____ Average	____ Above Average

Program Director Form
Continued

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

EVALUATION FORM TO BE COMPLETED BY PROGRAM DIRECTOR, PAGE TWO OF THREE

Name of Applicant: _____
How long have you known the applicant? _____

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? _____ Yes _____ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine? _____ Yes _____ No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? _____ Yes _____ No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.) _____ Yes _____ No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? _____ Yes _____ No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? _____ Yes _____ No

Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? _____ Yes _____ No

Do you know of a failure of the applicant to complete a residency training program(s)? _____ Yes _____ No

Does the applicant call upon consults when needed? _____ Yes _____ No

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please check the appropriate response. If you answer yes to any of these questions, please enclose an explanation.

Did the applicant take any leaves of absence or breaks from his/her medical education? _____ Yes _____ No

Was the applicant ever placed on probation or otherwise formally disciplined? _____ Yes _____ No

Were any limitations or special requirements imposed on the applicant because of questions of academic or technical competence? _____ Yes _____ No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluating this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

Program Director Form
Continued

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

EVALUATION FORM TO BE COMPLETED BY PROGRAM DIRECTOR, PAGE THREE OF THREE

Name of Applicant: _____

The above report is based on:

_____ Close personal observation
_____ General impression
_____ A composite of previous evaluations
_____ Other - Specify: _____

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend _____ for licensure in Vermont.
Name of Physician

Signed: _____ Date: _____

Print or Type Name and Title: _____

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

VERIFICATION OF FIFTH PATHWAY

To be completed by an official of the sponsoring institution:

Name of Institution: _____

Address: _____

_____

_____

I hereby certify that _____ was enrolled in the Fifth Pathway
Name

program at this institution from _____ / _____ / _____ to
Month Day Year

_____ / _____ / _____.
Month Day Year

Our records indicate that the applicant received a certificate of completion on

_____ / _____ / _____.
Month Day Year

Date: _____

(AFFIX SEAL)

Signed: _____
(Official of the Sponsoring Institution)

Print Name: _____

Title: _____

Telephone Number: _____

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

REQUEST FOR CONFIRMATION OF ECFMG® CERTIFICATION

Responses will be sent directly to the requesting *organization* and will include the date certification was issued and the valid-through status.

NOTE TO RESIDENCY PROGRAM DIRECTORS: Please visit the ECFMG website at www.ecfmg.org or contact ECFMG at the address below for the correct form to confirm certification status for international medical graduates entering residency or fellowship programs.

To confirm ECFMG certification status for an international medical graduate, please complete and return this form (via U.S. mail; **faxes will not be accepted)** to:

ECFMG Certification Verification Service, PO Box 13679, Philadelphia, PA 19101

**** A $25 fee will be assessed for each confirmation report issued. ****

Do not enclose payment with this request. An invoice will be sent to the *requesting organization* indicated below. In the event that a confirmation report cannot be issued because of incomplete or inconsistent data, no fee will be charged until a completed report can be issued.

Please type or print. Requests with incomplete or inaccurate information will not be processed.

USMLE™/ECFMG Identification Number: 0 - ☐☐☐-☐☐☐-☐

Physician's Name: _____ _____ _____
First Middle Last Name/Surname/Family Name

Date of Birth: _____ / _____ / _____
Day **Month** Year

Requesting Organization: _____

Organization Number: V-☐☐☐☐☐ Requests without this number will not be processed.

If this is your first request, please write "new vendor" in this space and an Organization Number will be issued.

Your Reference/Purchase Order # _____

Contact: _____
Name

_____ _____
Title Signature

Telephone Number (with Area Code) _____ - _____

Address to Which Confirmation Report Should be Sent: _____
Street Address

_____
Address Continued

_____
City State Zip Code

Note: Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the ECFMG Certification information or make it available to any party beyond this request as authorized by the physician. The information may only be used to confirm ECFMG Certification for the purpose for which the physician provided authorization.

Physicians who are ECFMG certified have passed the requisite medical science examination, English language proficiency test and the ECFMG Clinical Skills Assessment, if required for ECFMG Certification, and have had their medical education credentials verified by ECFMG. ECFMG Certification is a prerequisite for entry into ACGME-accredited residency or fellowship programs in the United States, is required for licensure to practice medicine in the United States, and is one of the eligibility requirements to take USMLE Step 3.

AMA Physician Profile Service Order Form

Please complete this form and attach DR-505 form when requesting AMA Physician Profiles.

___ Check only if new customer

ACCOUNT #: _____
CONTACT: _____ Date: ____/____/_____
ORGANIZATION: _____
DEPARTMENT: _____
ADDRESS: _____
_____
_____
CITY/STATE/ZIP: _____
PHONE: _____
FAX: _____
EMAIL: _____

For same day electronic ordering and delivery, logon to the AMA's ePhysician Profile Web site at: www.ama-assn.org/go/amaprofiles

If you have any questions, please call 800-665-2882 for ordering assistance.

Delivery Options (check one):

____ **Electronic Online Delivery**
Same day delivery.
$29 per Profile when 1 or 2 Profiles are ordered.
$27 per Profile when 3 or more Profiles are ordered.
Profiles delivered as a .PDF file.
Requires an email address above.
(pricing subject to change)

____ **Standard Mail Delivery**
Mailed within 10 business days.
$29 per Profile when 1 or 2 Profiles are ordered.
$27 per Profile when 3 or more Profiles are ordered.
All orders delivered via US First Class mail to the above address.
(pricing subject to change)

Ordering Methods:

Place your order online at:
www.ama-assn.org/go/amaprofiles

Mail in your order to:
AMA Physician Profile Service
Remittance Control Area/PPS
Accounting Department
PO Box 109054
Chicago, IL 60610

Fax in your order to:
312 464-5900
All faxed in orders require credit card information.

Number of Profiles Requested: _____

Order Total: $_____
Sales Tax: $_____
Total Due with Sales Tax: $_____
Enclosed Payment Amount: $_____

All Profile Orders are Subject to State Sales Tax*

AZ	CA	CN	CT	DC	GA
IA	IL	MN	NJ	NY	NC
		WI			

**Subject to change*

Note: If your organization is tax exempt, please include a copy of your 'Tax Exempt Certificate' with your order.

Method of Payment (select one):

____VISA ____Master Card ____AMEX

Credit Card Number: _____ Expiration: ___/_____

Authorizing Signature: _____

Card Holder Name (Print): _____

____Check enclosed (Make check payable to AMA Profiles. Include your account number on the check.)

Request Agreement

for Physician Profile Data from the Physician Masterfile

American Medical Association
Physicians dedicated to the health of America

Department of Credentialing Products
Division of Database Products and Licensing

Form DR-505

Requesting Organization

Individual or Department

Local Address

City State Zip

To assure proper identification of the physicians, please complete as much of this form as possible and mail with order form. See instructions on order form. Physician Profile Data will be prepared on the requested physicians and forwarded to your organization.

Type of Request (check one) ☐ Standard ☐ Express

Full Name of MD/DO Date of Birth

Professional Mailing Address

Medical School of Graduation Year ECFMG No.

Full Name of MD/DO Date of Birth

Professional Mailing Address

Medical School of Graduation Year ECFMG No.

Full Name of MD/DO Date of Birth

Professional Mailing Address

Medical School of Graduation Year ECFMG No.

To order **additional profiles**, please duplicate this form.

Important: Please provide number of physicians on this request _____ Date of this request _____

Purpose for which profiles are being requested

It is mutually agreed between the American Medical Association ("AMA") and the undersigned Requesting Organization that the Physician Profiles are provided to the Requesting Organization on the above named physicians with the understanding that: (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the Requesting Organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth above; (3) that no Profile information will be released, copied, extracted or otherwise usurped for the use by any other party, entity, organization or government agency; and (4) that upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the Requesting Organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to AMA immediately, but, in no event, later than 48 hours after such automatic termination.

AMA endeavors to maintain its physicians' records with information that is complete, current, and timely; however, because of possible reporting and processing delays, no representations or warranties as to the accuracy or completeness can be or is made. In consideration of the receipt of each physician record provided by AMA, the Requesting Organization hereby releases AMA, its agents and servants from any and all liability whatsoever for inaccurate or incomplete information in each such physician record.

Any signed Request Agreement transmitted by FAX machine shall be treated in all manner and respects as the original document and shall have the same legal and binding effect as any document with an original signature. At the request of the AMA any faxed document shall be re-executed by the requesting organization in an original form. The AMA and the undersigned hereby agree that neither shall raise the use of a FAX machine as a defense to this agreement and forever waive such a defense.

Agreement must be signed in order to process your request. Inquiry submitted and terms of data release agreed to by:

Signature Title

© 1999 American Medical Association

NATIONAL PRACTITIONER DATA BANK
HEALTHCARE INTEGRITY and PROTECTION DATA BANK
PO Box 10832, Chantilly, Virginia 20153-0832
www.npdb-hipdb.com

On-line Self-Query Process

- Log-on to web site for NPDB as shown above

TO SUBMIT A QUERY:

- Select "Report to and Query the Data Banks"
- Click on "Perform a Self-Query"
- Select the type of self-query you wish to perform
  Individual or organization

- Provide ALL required information

- Provide your credit card information (VISA, MasterCard, or Discover)
  (Checks or cash not accepted)

- Once all information is complete, click CONTINUE. A formatted copy of the self-query is generated immediately with a Data Bank Control Number (DCN) listed at the top of the page. Print this formatted copy, and keep the DCN to monitor the processing status of your self-query. To print a query from the IQRS, you must have Adobe Acrobat Reader version 4.0 or higher installed on your computer.

- To complete the self-query process, you **must sign the formatted self-query application in the presence of a notary public** and mail it to the NPDB-HIPDB. Self-queries received without notarization or with an incomplete notarization are rejected. Notarized forms that are missing credit card information will be rejected.

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

NATIONAL PRACTITIONER DATA BANK SELF QUERY

Effective September 1, 1990, the Federal government opened the National Practitioner Data Bank. This data bank, mandated by Congress, tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments.

You must self query this data bank on your own record as part of the application process for a Vermont medical license. Simply query the data bank using the attached form and when you receive the response, **SEND THE ORIGINAL, UNALTERED** response to the Board. You may keep a photocopy if you wish.

Before completing the data bank form, please contact the **Data Bank Help Line** for assistance: Help Line Toll Free Number: 1-800-767-6732.